		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014076

Facility Name: Sunny Hill Skilled Rehab Ctr

Address: 421 Doris Ave. (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-8710 **Fax #** (815) 727-8637

IDPA ID Number: 366006672001

Date of Initial License for Current Owners: 1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/01 to 11/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	250	Intermediate (ICF)	250	91,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,447	1,849	6,988	14,284	8
9	SNF/PED					9
10	ICF	57,659	17,223	3,500	78,382	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,106	19,072	10,488	92,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.63%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 6,759

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: No tax year Fiscal Year: 11/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	646,257		15,242	661,499		661,499		661,499			1
2	Food Purchase		697,690		697,690		697,690	(4,951)	692,739			2
3	Housekeeping	712,997	101,491		814,488		814,488		814,488			3
4	Laundry	180,743		33,969	214,712		214,712		214,712			4
5	Heat and Other Utilities			256,769	256,769		256,769		256,769			5
6	Maintenance	202,152	33,489	215,593	451,234		451,234		451,234			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,742,149	832,670	521,573	3,096,392		3,096,392	(4,951)	3,091,441			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	5,477,572	667,062	752,257	6,896,891		6,896,891		6,896,891			10
10a	Therapy		15,922	683,537	699,459		699,459		699,459			10a
11	Activities	238,982			238,982		238,982		238,982			11
12	Social Services	228,506			228,506		228,506		228,506			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,945,060	682,984	1,439,394	8,067,438		8,067,438		8,067,438			16
	C. General Administration											
17	Administrative	130,222			130,222		130,222		130,222			17
18	Directors Fees											18
19	Professional Services			66,149	66,149		66,149	436,371	502,520			19
20	Dues, Fees, Subscriptions & Promotions			29,829	29,829		29,829	(5,295)	24,534			20
21	Clerical & General Office Expenses	320,376	22,576	35,585	378,537		378,537	31,042	409,579			21
22	Employee Benefits & Payroll Taxes			60,319	60,319		60,319	2,728,316	2,788,635			22
23	Inservice Training & Education			3,087	3,087		3,087		3,087			23
24	Travel and Seminar			1,769	1,769		1,769		1,769			24
25	Other Admin. Staff Transportation			1,014	1,014		1,014		1,014			25
26	Insurance-Prop.Liab.Malpractice							291,332	291,332			26
27	Other (specify):*											27
28	**TOTAL General Administration**	450,598	22,576	197,752	670,926		670,926	3,481,766	4,152,692			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,137,807	1,538,230	2,158,719	11,834,756		11,834,756	3,476,815	15,311,571			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr #0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			295,416	295,416		295,416		295,416			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40	40		40	(40)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			100,744	100,744		100,744		100,744			35
36	Other (specify):*											36
37	**TOTAL Ownership**			396,200	396,200		396,200	(40)	396,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		228,391	9,155	237,546		237,546		237,546			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							164,250	164,250			42
43	Other (specify):* Nonallowable Costs											43
44	**TOTAL Special Cost Centers**		228,391	9,155	237,546		237,546	164,250	401,796			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,137,807	1,766,621	2,564,074	12,468,502		12,468,502	3,641,025	16,109,527			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,951)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(40)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,100)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	(929)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,020)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,652,045		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,652,045		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,641,025		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home
Facility ID#: 0014076
12/01/01 - 11/30/02 **Page 5: Line 29 - Other**

Non-allowable Expenses	Amount	Ref
Chamber of Commerce dues	(195)	20
Offset miscellaneous income	(734)	21
	(929)	

Sunny Hill Skilled Rehab Ctr

ID# 0014076

Report Period Beginning: 12/01/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(4,951)	0	0	0	0	0	0	0	0	0	0	(4,951)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,951)	0	0	0	0	0	0	0	0	0	0	(4,951)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	436,371	0	0	0	0	0	0	0	0	0	436,371	19
20	Fees, Subscriptions & Promotions	(5,100)	0	0	0	0	0	0	0	0	0	0	(5,100)	20
21	Clerical & General Office Expenses	0	31,776	0	0	0	0	0	0	0	0	0	31,776	21
22	Employee Benefits & Payroll Taxes	0	2,728,316	0	0	0	0	0	0	0	0	0	2,728,316	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	291,332	0	0	0	0	0	0	0	0	0	291,332	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,100)	3,487,795	0	0	0	0	0	0	0	0	0	3,482,695	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,051)	3,487,795	0	0	0	0	0	0	0	0	0	3,477,744	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40)	0	0	0	0	0	0	0	0	0	0	(40)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(40)	0	0	0	0	0	0	0	0	0	0	(40)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	164,250	0	0	0	0	0	0	0	0	0	164,250	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	164,250	0	0	0	0	0	0	0	0	0	164,250	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,091)	3,652,045	0	0	0	0	0	0	0	0	0	3,641,954	45

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Will County	100	N/A		Will County	Joliet	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional services	$	Will County	100.00%	$ 436,371	$ 436,371	1
2	V	21	Film processing		Will County	100.00%	31,776	31,776	2
3	V	22	Employee benefits		Will County	100.00%	2,728,316	2,728,316	3
4	V	26	Insurance		Will County	100.00%	291,332	291,332	4
5	V	42	Provider Tax		Will County	100.00%	164,250	164,250	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 3,652,045	$ * 3,652,045	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2	See attached list of	County Board									2
3	Board Members	Member	Administrative	0.00	None	< 1 hr	0.00	N/A	None	N/A	3
4											4
5											5
6	Note: No members of the County Board provided direct services to the nursing home. In addition, no Board member had ownership in an entity that conducted										6
7		business transactions with the nursing home during the reporting period.									7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Will County
Street Address: 302 N. Chicago
City / State / Zip Code: Joliet, IL 60432
Phone Number: (815) 740-4607
Fax Number: (815) 740-4319

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional services	Number of Warrants	N/A	1	$ 436,371	$		$ 436,371	1
2	21	Film Processing	Estimated time	N/A	1	31,776			31,776	2
3	22	Employee benefits	Direct cost	N/A	1	2,728,316			2,728,316	3
4	26	Insurance	Direct cost	N/A	1	291,332			291,332	4
5	42	Provider Tax	Direct cost	N/A	1	164,250			164,250	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,652,045	$		$ 3,652,045	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Various		X	Finance charges							40	8
9	TOTAL Facility Related						$	$			$ 40	9
	B. Non-Facility Related*											
10												10
11								Less: Non-allowable finance charges			(40)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (40)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

Not applicable. County does not pay real estate tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Hill Skilled Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

TELEPHONE (815) 727-8710 FAX #: (815) 727-8637

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A - County does not pay real estate tax.		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 128,067 B. General Construction Type: Exterior Brick Frame Steel, concrete block Number of Stories two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		1972	$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1972	1972	$ 1,375,843	$ 34,396	40	$ 34,396	$	$ 1,060,542	4
5	150		1976	1976	1,198,083	29,952	40	29,952		793,728	5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing			1970	727		20			727	9
10	Landscaping			1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance			1973	37,155		10-20			37,155	11
12	Door			1974	38,466		20			38,466	12
13	Asphalt Paving			1975	155,856		15			155,856	13
14	Landscaping			1976	57,254		10-15			57,254	14
15	Sewer and Water			1976	26,031	868	30	868		23,002	15
16	Plumbing			1972	183,817		25			183,817	16
17	Heating and Electrical			1972	522,443		20			522,443	17
18	Plumbing			1976	262,534		25			262,534	18
19	Heating and Electrical			1976	508,942		20			508,942	19
20	Sprinkler System and Paving			1975	83,460		25			83,460	20
21	Repairs/Roof			1981	107,858		15			107,858	21
22	Building Improvement			1987	819,813	32,792	25	32,792		508,278	22
23	Reroof A & B Roofs			1985	85,920	4,296	20	4,296		75,180	23
24	Parking Lot Lights			1989	3,040		15			3,040	24
25	Reroof/Hot Water			1992	162,867	8,143	20	8,143		85,502	25
26	Washer Repair			1992	3,284		3			3,284	26
27	Site Improvements			1993	101,451	6,764	15	6,764		64,258	27
28	Laundry Renovation			1994	108,852	7,256	15	7,256		61,676	28
29	Paving Parking Lot			1995	66,260	4,417	15	4,417		33,127	29
30	Laundry, Air Conditioner			1996	362,815	30,235	12	30,235		196,527	30
31	Elevator Repair			1997	4,990	499	10	499		2,745	31
32	Tile			1992	7,040		5			7,040	32
33	Elevator Repair			1996	2,212		3			2,212	33
34	Sheeting			1993	3,685		3			3,685	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Site Improvement	1998	$ 2,936	$ 294	10	$ 294	$	$ 1,323	37
38	Electrical Work	1998	2,085	209	10	209		940	38
39	Plumbing Repair	1998	2,440	244	10	244		1,098	39
40	Boiler Repair	1998	4,273	427	10	427		1,922	40
41	Fence	1999	1,000	100	10	100		350	41
42	Air Conditioning Repair	1999	6,284	628	10	628		2,198	42
43	Boiler Repair	1999	4,965	497	10	497		1,739	43
44	Doors	1999	4,842	484	10	484		1,694	44
45	Carpeting	1999	1,649	165	10	165		577	45
46	Nurses Station	1999	53,554	5,355	10	5,355		17,404	46
47	Wallpaper	2000	840	84	10	84		210	47
48	Vinyl Board	2000	823	82	10	82		205	48
49	Office Compressor	2000	1,205	120	10	120		300	49
50	Fire System	2000	3,441	344	10	344		860	50
51	Fence	2000	936	94	10	94		235	51
52	Air Ducts	2000	3,090	309	10	309		773	52
53	Service Work	2000	1,573	157	10	157		393	53
54	Parking Lot	2000	4,860	486	10	486		1,215	54
55	Circular Pumps	2000	1,079	108	10	108		270	55
56	Boiler repair	2001	5,326	533	10	533		799	56
57									57
58	Plumbing	2002	11,756	588	10	588		588	58
59	Air Cleaner	2002	2,020	101	10	101		101	59
60	Boiler	2002	5,658	283	10	283		283	60
61	HVAC Control	2002	2,800	140	10	140		140	61
62	Fire & Smoke Dampers	2002	26,087	1,304	10	1,304		1,304	62
63	Doors	2002	4,155	208	10	208		208	63
64	Fireproof Framing	2002	2,730	137	10	137		137	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,504,680	$ 173,099		$ 173,099	$	$ 4,971,179	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,220,665	$ 122,067	$ 122,067	$	10	$ 916,919	71
72	Current Year Purchases	4,991	250	250		10	250	72
73	Fully Depreciated Assets	768,603					768,603	73
74								74
75	TOTALS	$ 1,994,259	$ 122,317	$ 122,317	$		$ 1,685,772	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,523,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 295,416	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 295,416	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,656,951	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94	N/A		94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 100,744 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Nursing Home
Facility ID#: 0014076
12/01/01 - 11/30/02 **Page 14: Line 16 - Description of Rental Equipment**

Helium tanks	481
Ice machine	1,774
Postage meter	329
Lift rental	25,368
Mattress rental	40,778
Blood monitor rental	5,005
Respiratory therapy equipment	22,260
Computer rental	1,509
Bladder scanner	2,322
Pharmacy equipment rental	918
	100,744

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	4,065	$ 243,894	$	4,065	$ 243,894	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		391	23,440		391	23,440	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,092	185,525		3,092	185,525	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				228,391		228,391	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A	See 16A			7,518	234,680	15,922	7,518	250,602	13
14	TOTAL			$	15,066	$ 687,539	$ 244,313	15,066	$ 931,852	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076 **Page 16: Line 13 - Other**
12/01/01 - 11/30/02

Service	Schedule V Reference	Outside Practitioner Units	Outside Practitioner Cost	Supplies	Total
Respiratory Therapy	10A(2, 3)	7,518	225,525	15,922	241,447
Laboratory Fees	39(3)		9,155		9,155
Total Line 13		7,518	234,680	15,922	250,602

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	60,532	60,532	15
16	Equipment, at Historical Cost	1,983,380	1,994,259	16
17	Accumulated Depreciation (book methods)	(6,658,628)	(6,656,951)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,854,432	$ 1,866,988	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,854,432	$ 1,866,988	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 131,372	$ 131,372	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	758,663	758,663	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 890,035	$ 890,035	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 890,035	$ 890,035	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 964,397	$ 976,953	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,854,432	$ 1,866,988	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,302,076	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,302,076	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,288,914)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,288,914)	17
	B. Transfers (Itemize):		
18	**Interfund transfers**	1,951,235	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,951,235	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 964,397	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,322,230	1
2	Discounts and Allowances for all Levels	(148,327)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,173,903	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,951	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,951	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous revenue	734	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 734	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,179,588	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,096,392	31
32	Health Care	8,067,438	32
33	General Administration	670,926	33
	B. Capital Expense		
34	Ownership	396,200	34
	C. Ancillary Expense		
35	Special Cost Centers	237,546	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,468,502	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,288,914)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,288,914)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation. This entity is exempt.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,859	2,080	$ 69,844	$ 33.58	1
2	Assistant Director of Nursing	1,912	2,080	53,923	25.92	2
3	Registered Nurses	29,711	31,458	758,240	24.10	3
4	Licensed Practical Nurses	57,909	62,897	1,354,591	21.54	4
5	Nurse Aides & Orderlies	221,288	238,424	3,011,485	12.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,125	14,495	229,489	15.83	8
9	Activity Director	2,010	2,080	45,481	21.87	9
10	Activity Assistants	16,053	17,526	193,501	11.04	10
11	Social Service Workers	10,475	11,408	228,506	20.03	11
12	Dietician					12
13	Food Service Supervisor	3,808	4,160	94,654	22.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	46,440	49,596	551,603	11.12	15
16	Dishwashers					16
17	Maintenance Workers	10,549	11,136	202,152	18.15	17
18	Housekeepers	58,405	64,078	712,997	11.13	18
19	Laundry	15,525	17,034	180,743	10.61	19
20	Administrator	1,936	2,080	85,119	40.92	20
21	Assistant Administrator	1,976	2,080	45,103	21.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,788	21,431	320,376	14.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	512,769	554,043	$ 8,137,807 *	$ 14.69	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	393	$ 14,719	1(3)	35
36	Medical Director	Monthly	3,600	9(3)	36
37	Medical Records Consultant	26	1,290	10(3)	37
38	Nurse Consultant	30	915	10(3)	38
39	Pharmacist Consultant	Monthly	300	10(3)	39
40	Physical Therapy Consultant	53	2,653	10A(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	50	2,500	10A(3)	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychological Cons.	7	210	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	559	$ 26,187		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,796	$ 205,670	10(3)	50
51	Licensed Practical Nurses	8,169	261,748	10(3)	51
52	Nurse Aides	13,670	268,405	10(3)	52
53	TOTAL (lines 50 - 52)	26,635	$ 735,823		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mickie Stanley	Administrator	0	$ 85,119
Pam Weitting	Asst. Admin.	0	30,391
Mary Sandelski	Asst. Admin.	0	14,712
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,222

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Schedule 21C	Various	66,149
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 66,149

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 287,233
Unemployment Compensation Insurance	7,037
FICA Taxes	622,569
Employee Health Insurance	1,246,767
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	551,767
Uniforms	60,319
Employee Morale	12,943
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,788,635

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,022
Health Care Worker Background Check	
(Indicate # of checks performed 202)	2,434
Illinois Health Care Association dues	12,751
County Nursing Home Association dues	2,540
Promotion & advertising	5,100
Dues & subscriptions	2,762
MW Automated Time System license	1,035
Miscellaneous fees	1,185
Less: Public Relations Expense	(195)
Non-allowable advertising	(5,100)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,769
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,769

* Attach copy of IMRF notifications

**See instructions.

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076 **Schedule 21 C: Professional Services**
12/01/01 - 11/30/02

Duane Morris LLP	Legal	24,469
UHC/Accu-med Services, Inc.	Software support	7,183
Health Data Systems, Inc	Software support	8,168
Altschuler, Melvoin & Glasser LLP	Accounting	9,592
Midwest Environmental	Environmental consulting	250
Dimante, Net Services	Internet service	300
Richard Czerniak	Medicare consultant	7,601
Medworks Health Services	Drug Screening	34
Joliet Federation of Musicians	Music	2,060
Ralph Zuppa	Piano tuner	120
Mutual of Omaha	Medicare billing fees	910
Patty Ciesla	Operations consulting	5,462
Sub total agreeing to Sch. V, line 19, col. 3		**66,149**
Allocated from Will County		436,371
Total agreeing to Sch. V, line 19, col. 8		**502,520**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6					N/A								
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/01 Ending: 11/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IHCA-12,751; County NH Assn.-2,540**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wermer, Rogers, Daran & Ryan** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Sunny Hill Skilled Rehab** **04:27 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	3,641,025	equal to	3,641,025	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	295,416	equal to	295,416	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	100,744	equal to	100,744	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	458,012	equal to	699,459	-241,447	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	244,313	equal to	244,313	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	3,096,392	equal to	3,096,392	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	8,067,438	equal to	8,067,438	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	670,926	equal to	670,926	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	396,200	equal to	396,200	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	237,546	equal to	237,546	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	0	equal to	0	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	5,248,083	equal to	5,477,572	-229,489	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	238,982	equal to	238,982	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	228,506	equal to	228,506	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	646,257	equal to	646,257	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	202,152	equal to	202,152	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	712,997	equal to	712,997	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	180,743	equal to	180,743	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	130,222	equal to	130,222	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	320,376	equal to	320,376	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	8,137,807	equal to	8,137,807	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	14,719	< or = to	15,242	-523	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,600	< or = to	3,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	738,328	< or = to	752,257	-13,929	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	130,222	equal to	130,222	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	66,149	equal to	66,149	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	2,788,635	equal to	2,788,635	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	24,534	equal to	24,534	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,769	equal to	1,769	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	164,250	equal to		0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	2,728,316	-2,728,316	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,759	equal to	6,988	-229	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	3,652,045	equal to	3,652,045	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	25,000	equal to	25,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,504,680	equal to	6,504,680	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,994,259	equal to	1,994,259	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,656,951	equal to	6,656,951	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	964,397	equal to	964,397	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-2,288,914	equal to	-2,288,914	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,854,432	equal to	1,854,432	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	646,257	0	15,242	661,499	0	661,499	0	661,499
2. Food P	0	697,690	0	697,690	0	697,690	-4,951	692,739
3. Housek	712,997	101,491	0	814,488	0	814,488	0	814,488
4. Laundry	180,743	0	33,969	214,712	0	214,712	0	214,712
5. Heat ar	0	0	256,769	256,769	0	256,769	0	256,769
6. Mainter	202,152	33,489	215,593	451,234	0	451,234	0	451,234
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	1,742,149	832,670	521,573	3,096,392	0	3,096,392	-4,951	3,091,441
9. Medical	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursin	5,477,572	667,062	752,257	6,896,891	0	6,896,891	0	6,896,891
10a. Ther	0	15,922	683,537	699,459	0	699,459	0	699,459
11. Activit	238,982	0	0	238,982	0	238,982	0	238,982
12. Social	228,506	0	0	228,506	0	228,506	0	228,506
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	5,945,060	682,984	1,439,394	8,067,438	0	8,067,438	0	8,067,438
17. Admin	130,222	0	0	130,222	0	130,222	0	130,222
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	66,149	66,149	0	66,149	436,371	502,520
20. Fees,	0	0	29,829	29,829	0	29,829	-5,295	24,534
21. Clerica	320,376	22,576	35,585	378,537	0	378,537	31,042	409,579
22. Emplo	0	0	60,319	60,319	0	60,319	2,728,316	2,788,635
23. Inserv	0	0	3,087	3,087	0	3,087	0	3,087
24. Travel	0	0	1,769	1,769	0	1,769	0	1,769
25. Other	0	0	1,014	1,014	0	1,014	0	1,014
26. Insura	0	0	0	0	0	0	291,332	291,332
27. Other	0	0	0	0	0	0	0	0
28. Total (	450,598	22,576	197,752	670,926	0	670,926	3,481,766	4,152,692
29. Total (	8,137,807	1,538,230	2,158,719	########	0	########	3,476,815	########
30. Depre	0	0	295,416	295,416	0	295,416	0	295,416
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	40	40	0	40	-40	0
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	100,744	100,744	0	100,744	0	100,744
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	396,200	396,200	0	396,200	-40	396,160
38. Medic	0	0	0	0	0	0	0	0
39. Ancilla	0	228,391	9,155	237,546	0	237,546	0	237,546
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	0	0	0	0	164,250	164,250
43. Other	0	0	0	0	0	0	0	0
44. Total S	0	228,391	9,155	237,546	0	237,546	164,250	401,796
45. Grand	8,137,807	1,766,621	2,564,074	########	0	########	3,641,025	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	0	0
2. Cash - F	0	0
3. Account	0	0
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	0	0
7. Other Pr	0	0
8. Account	0	0
9. Other (s	0	0
10. Total c	0	0
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	25,000	25,000
14. Buildin	6,444,148	6,444,148
15. Leaseh	60,532	60,532
16. Equipn	1,983,380	1,983,380
17. Accum	########	########
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	0	0
24. Total L	1,854,432	1,854,432
25. Total A	1,854,432	1,854,432
CURRENT LIABILITIES		
26. Accour	131,372	131,372
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	758,663	758,663
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other C	0	0
37. Other C	0	0
38. Total C	890,035	890,035
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	0
46.Total Li	890,035	890,035
47.Total Eo	964,397	964,397
48.Total Li	1,854,432	1,854,432

		Balance per Medicaid Trial Balance
1.	Gross F	########
2.	Discour	-148,327
	Subtota	########
4.	Day Ca	0
5.	Other C	0
6.	Therapy	0
7.	Oxygen	0
	Subtota	-
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	4,951
15.	Telepł	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Laborá	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	4,951
24.	Contril	0
25.	Interes	0
	Subtot	-
27.	Other	0
28.	Other	734
	Subtot	734
30.	Total F	########
31.	Gener	3,096,392
32.	Health	8,067,438
33.	Gener	670,926
34.	Owner	396,200
35.	Specia	237,546
35.	Provid	0
37.	Other	0
40.	Total E	########
41.	Incom	########
42.	Incom	0
43.	Net In	########

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Line 16 for mortgage insurance.